Chronic respiratory conditions

Web report | Last updated: **18 Feb 2026** | Topic: Chronic respiratory conditions

About

Respiratory conditions affect the airways, including the lungs as well as the passages that transfer air from the mouth and nose into the lungs. They can be long lasting (chronic) or short term (acute) and can cause ill health, disability and death.

Cat. no: ACM 42

Key findings

- Between 2001 and 2022, the prevalence of chronic respiratory conditions increased by around 10%, from 31% to 34%
- In 2023–24, 4.1% (521,000) of all hospitalisations had a respiratory condition as the principal diagnosis
- In 2023–24, $5.8 billion of expenditure in the Australian health system was attributed to respiratory conditions
- Over one-quarter (28%) of all deaths in 2023 involved a respiratory condition

Explore related articles

Asthma
- Asthma
- First Nations people with asthma 2023
- National asthma indicators

Chronic obstructive pulmonary disease
- Chronic obstructive pulmonary disease

Bronchiectasis
- Bronchiectasis

Allergic rhinitis
- Allergic rhinitis (hay fever)

Summary

Chronic respiratory conditions is an Australia's health topic

In this section

What are chronic respiratory conditions?

Chronic respiratory conditions affect the airways, including the lungs and the passages that transfer air from the mouth and nose into the lungs. These conditions are characterised by symptoms such as wheezing, shortness of breath, chest tightness and cough.

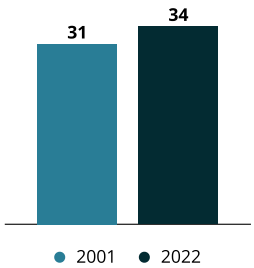
In February 2019, the Department of Health, Disability and Ageing released the National Strategic Action Plan for Lung Conditions (the Action Plan), which includes Chronic Obstructive Pulmonary Disease (COPD), asthma and bronchiectasis in its scope. The Action Plan outlines a comprehensive, collaborative and evidence-based approach to reducing the individual and societal burden of lung conditions and improving lung health (Department of Health, Disability and Ageing 2019). The Action Plan can be found at Lung Foundation Australia.

For more information on what is covered by the term 'chronic respiratory conditions' for each data source, see the Technical notes and Data tables.

Articles on specific chronic respiratory conditions

Asthma
Allergic rhinitis (Hay fever)
Chronic Obstructive Pulmonary Disease
Bronchiectasis

How common are chronic respiratory conditions?

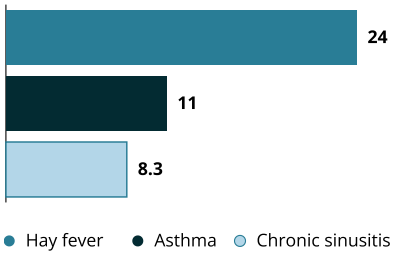


The prevalence of chronic respiratory conditions

The prevalence of chronic respiratory conditions increased from 31% in 2001 to 34% in 2022.
Source: National Health Survey 2022

Around 8.5 million people (34%) in Australia were estimated to have chronic respiratory conditions, according to self-reported data in the Australian Bureau of Statistics (ABS) 2022 National Health Survey (NHS) (ABS 2023a).

In 2022, allergic rhinitis (hay fever) was the most common chronic respiratory condition (24%), followed by asthma (11%) and chronic sinusitis (8.3%).
Source: National Health Survey 2022



Based on the 2022 NHS:

- Around 32% of males and 35% of females were estimated to be living with a chronic respiratory condition.
- The prevalence of chronic sinusitis and chronic obstructive pulmonary disease (COPD) generally increased with age, while asthma and allergic rhinitis were more prevalent across the life course (ABS 2023a).

Trends over time

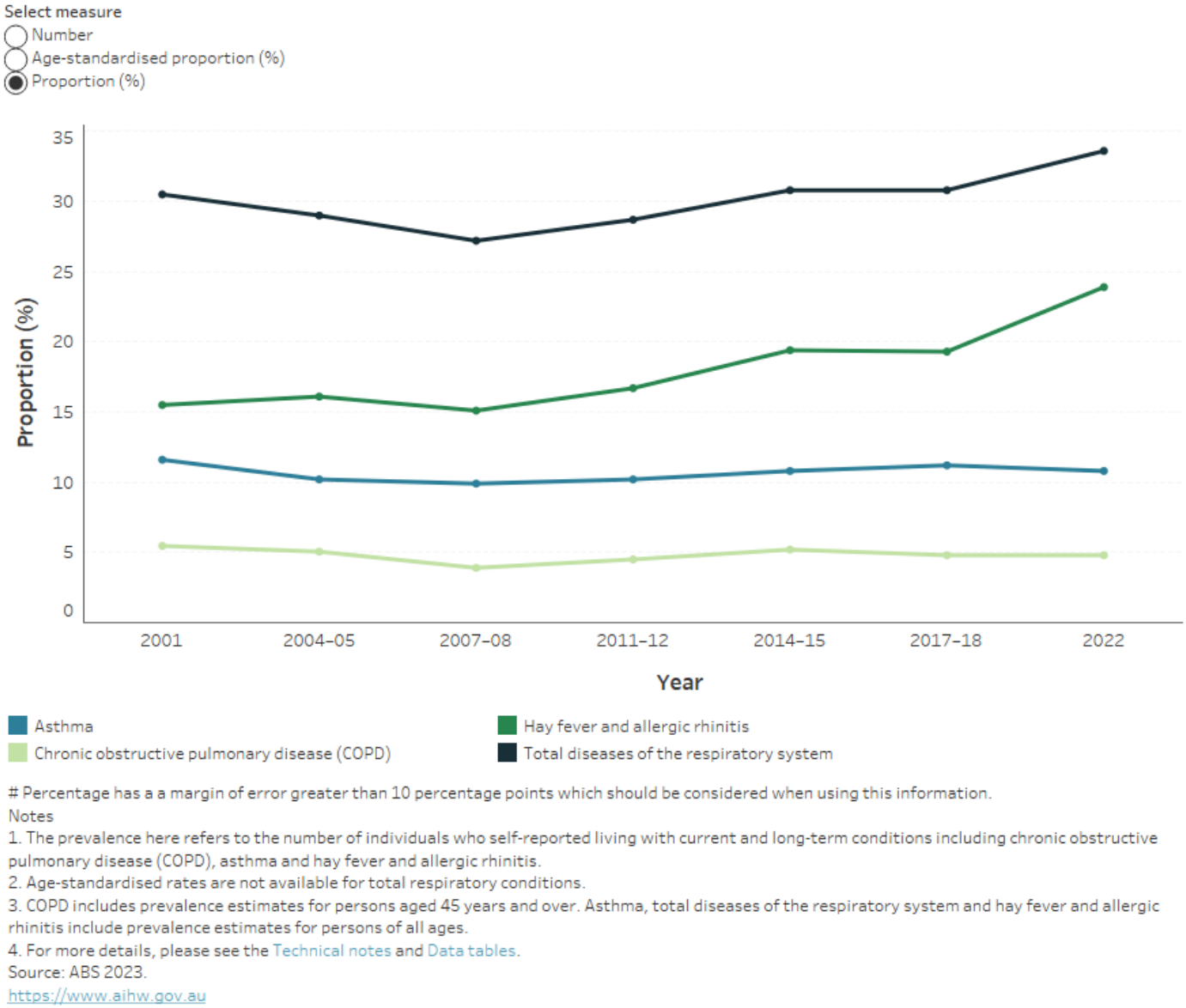
Between 2001 and 2022 the prevalence of chronic respiratory conditions increased from 31% to 34%, a statistically significant change. However, prevalence trends varied by condition:

- Allergic rhinitis prevalence increased from 16% to 24% (statistically significant).
- Asthma prevalence remained stable at around 11% (no statistically significant change).
- COPD prevalence among people aged 45 and over decreased slightly from 5.5% to 4.8% (not statistically significant) (Figure 1).

Data note: COPD prevalence estimates

In the ABS NHS, COPD is measured from self-reported emphysema, chronic bronchitis and (since 2022) chronic airflow limitation. At younger ages, many people with emphysema and chronic bronchitis will not have met the diagnostic criteria for COPD. In this report, COPD prevalence from the NHS is reported for ages 45 and over to give a closer estimate of diagnosable COPD.

Figure 1: Prevalence of selected respiratory conditions, by age and sex (2022) and over time (2001 to 2022)



Percentage has a a margin of error greater than 10 percentage points which should be considered when using this information.
Notes
1. The prevalence here refers to the number of individuals who self-reported living with current and long-term conditions including chronic obstructive pulmonary disease (COPD), asthma and hay fever and allergic rhinitis.
2. Age-standardised rates are not available for total respiratory conditions.
3. COPD includes prevalence estimates for persons aged 45 years and over. Asthma, total diseases of the respiratory system and hay fever and allergic rhinitis include prevalence estimates for persons of all ages.
4. For more details, please see the Technical notes and Data tables.
Source: ABS 2023.
https://www.aihw.gov.au

For more information, see Asthma, Chronic obstructive pulmonary disease and Allergic rhinitis (Hay fever).

Remoteness and socioeconomic areas

In 2022, the prevalence of respiratory conditions was:

- highest in *Inner regional* areas (35%) and lowest in *Outer regional* and *Remote* areas (31%)
- similar across socioeconomic areas (34% in areas of most and least disadvantage) (AIHW analysis of ABS 2023b).

Treatment and management of chronic respiratory conditions

Primary care for respiratory conditions

General practitioners (GP) play an important role in managing chronic respiratory conditions in the community, but there is currently no nationally consistent primary health care data collection to monitor provision of care by GPs.

For more information, see *General practice, allied health and other primary care services*.

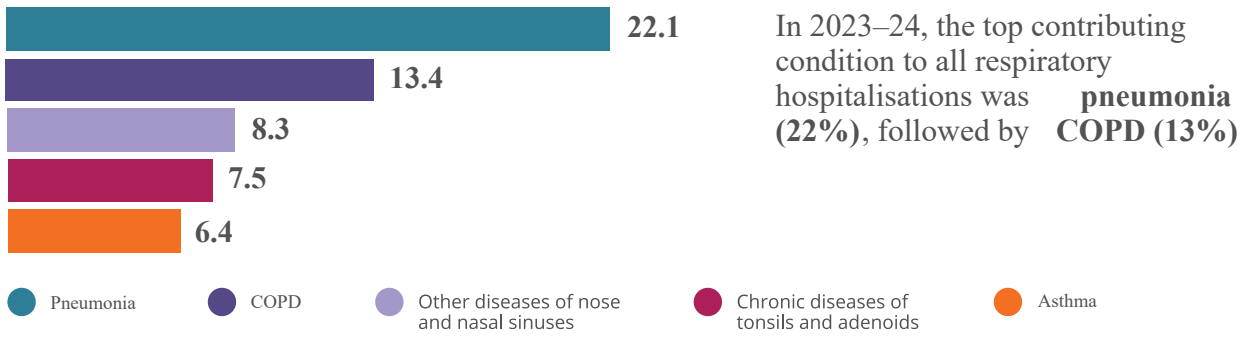
Hospitalisations for respiratory conditions

People with chronic respiratory conditions require admission to hospital when they cannot be managed at home or by a GP, or their symptoms exacerbate acutely.

In 2023–24, there were **521,000** hospitalisations with a respiratory condition as the principal diagnosis, representing **4.1%** of all hospitalisations.

Data from the National Hospital Morbidity Database (NHMD) for 2023–24 is shown in Figure 2.

Figure 2: Top five contributing conditions to respiratory hospitalisations, 2023–24



In 2023–24 for all respiratory conditions (principal diagnosis):

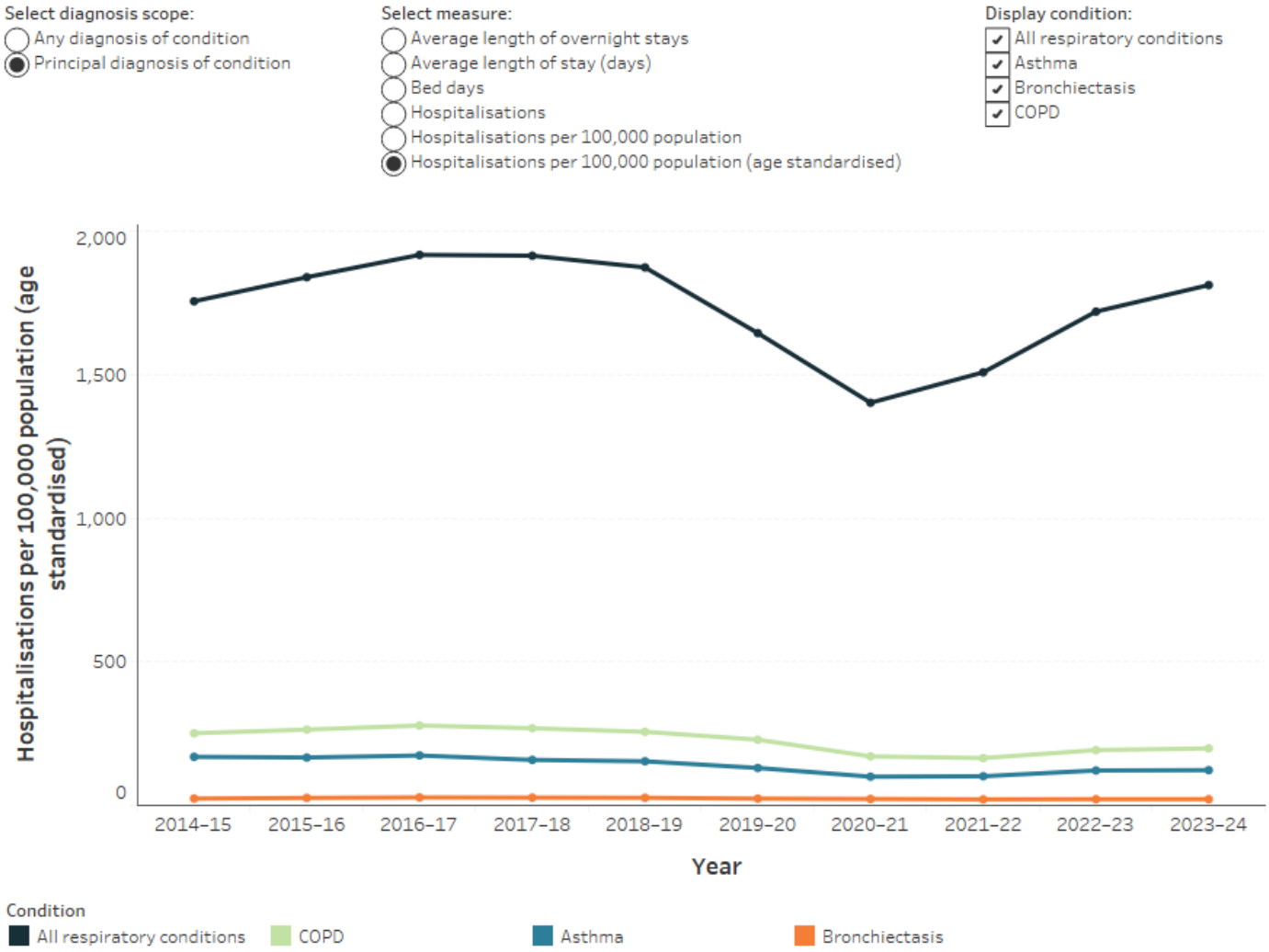
- the rate of hospitalisations was slightly higher among males than females (2,000 and 1,900 per 100,000 population, respectively)
- accounted for 1.8 million bed days, representing 5.4% of all bed days
- the average length of stay was 3.5 days
- 74% of respiratory condition hospitalisations were overnight stays.

Trends over time

From 2014–15 to 2023–24, the age-standardised hospitalisation (principal diagnosis) rate for:

- Asthma decreased from around 170 to 125 per 100,000 population.
- All respiratory conditions remained relatively stable, ranging between 1,700 and 1,900 per 100,000 population in most years. There was a notable decrease in hospitalisation rates between 2019–20 and 2021–22, likely due to the COVID-19 pandemic (Figure 3).

Figure 3: Hospitalisations for respiratory conditions, age and sex (2023–24), trends over time (2014–15 to 2023–24)



Notes
1. For more details, please see the Technical notes and Data tables.
2. Rates have been age-standardised to the 2001 Australian Standard Population as at 30 June 2001. For asthma, the age groups are 5-year age groups up to 85+ years. For COPD, the age groups are: 5-year age groups from 45 years up to 85+ years.
Source: AIHW analysis of the NHMD
https://www.aihw.gov.au

Remoteness and socioeconomic areas

In 2023–24, the age-standardised rate of hospitalisations due to all respiratory conditions (as the principal diagnosis) was:

- highest in *Remote* and *Very remote* areas (3,000 per 100,000 population), and lowest in *Major cities* (1,700 per 100,000 population)
- highest in areas of most socioeconomic disadvantage (2,200 per 100,000 population) and lowest in areas of least socioeconomic disadvantage (1,500 per 100,000 population).

Emergency department presentations for respiratory conditions

In 2024–25, there were around 653,000 ED presentations where respiratory conditions were the principal diagnosis. This is a rate of 2,400 per 100,000 population, representing 7.2% of all ED presentations.

In 2024–25, the rate of ED presentations due to all respiratory conditions as the principal diagnosis in *Remote* and *Very remote* areas was more than 3 times the rate in *Major cities* (6,100 and 1,900 per 100,000 population, respectively).

People with respiratory conditions may present to the emergency department (ED) when symptoms exacerbate acutely.

In 2024–25:

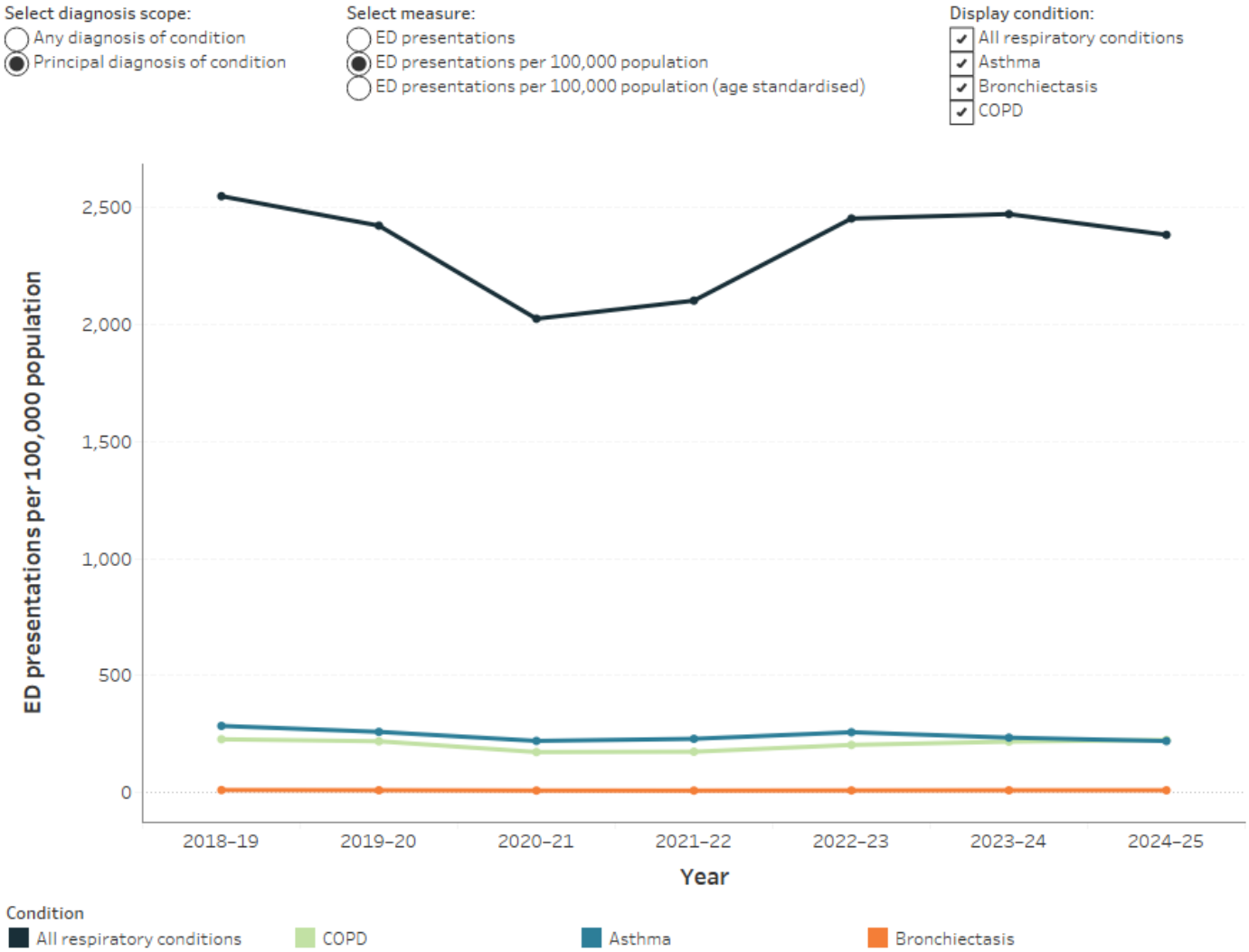
- There were around 653,000 ED presentations where respiratory conditions were the principal diagnosis. This is a rate of 2,400 per 100,000 population, representing 7.2% of all ED presentations.
- There were around 704,000 ED presentations where the diagnosis was a respiratory condition (principal and/or additional) (2,600 per 100,000 population) (Figure 4).
- The rate of ED presentations where respiratory conditions were the principal diagnosis was slightly higher among males than females (2,400 and 2,300 per 100,000 population, respectively).
- COPD and asthma accounted for 9.4% and 9.2% of all respiratory-related ED presentations (principal diagnosis), respectively.

Trends over time

Between 2018–19 and 2024–25, the rate of ED presentations:

- due to all respiratory conditions (principal diagnosis) decreased from around 2,600 to 2,400 per 100,000 population
- due to asthma (principal diagnosis) decreased from 285 to 220 per 100,000 population (Figure 4).

Figure 4: Emergency department presentations for respiratory conditions, age and sex (2024–25), trends over time (2018–19 to 2024–25)



Notes
1. For more details, please see the Technical notes and Data tables.
2. Rates have been age-standardised to the 2001 Australian Standard Population as at 30 June 2001. For asthma, the age groups are 5-year age groups up to 85+ years. For COPD, the age groups are: 5-year age groups from 45 years up to 85+ years.
Source: AIHW analysis of the NHMD
https://www.aihw.gov.au

Remoteness and socioeconomic areas

In 2024–25, the age-standardised rate of ED presentations due to all respiratory conditions as the principal diagnosis:

- was higher in *Remote* and *Very remote* areas compared to *Major cities* (6,200 and 2,000 per 100,000 population, respectively)
- was highest in areas of most socioeconomic disadvantage, and lowest in areas of least socioeconomic disadvantage (3,200 and 1,500 per 100,000 population, respectively).

Impact of chronic respiratory conditions

Chronic respiratory conditions have varying degrees of impact on the physical, psychological, and social wellbeing of people living with the conditions, depending on disease severity and their level of control.

Burden of disease due to respiratory conditions

In 2024, the respiratory conditions disease group accounted for **7.2%** of total disease burden, **8.4%** of non-fatal burden and **5.7%** of fatal burden.

In 2024, the respiratory conditions disease group accounted for 7.2% of total disease burden (also known as disability adjusted life years or DALY), 8.4% of non-fatal burden (also known as 'years lived with disability' or YLD) and 5.7% of fatal burden (also known as years of life lost, or YLL) (AIHW 2024a).

In 2024:

- The rate of burden for the respiratory conditions disease group was under 10 for those aged up to 49, increasing to 20.9 for those aged 60–64 and rising to 54.6 DALY per 1,000 population for those aged 75–79.
- Most of the respiratory condition fatal burden was due to COPD (72%). The non-fatal burden was more evenly split between asthma (51%) and COPD (38%).

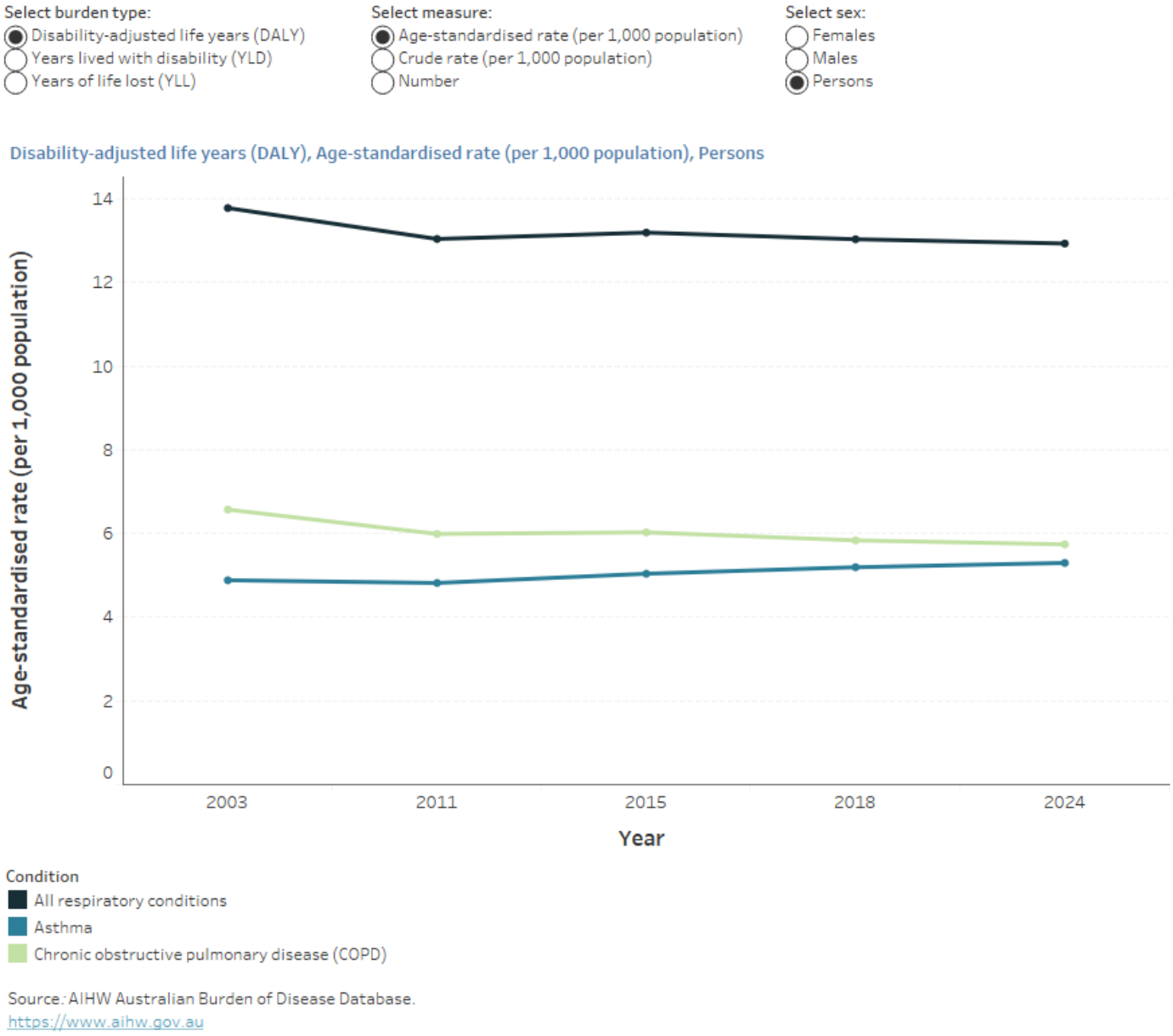
Trends over time

After adjusting for different population age structures over time, the overall rate of respiratory conditions burden decreased by 6.2% between 2003 and 2024 (14 to 13 DALY per 1,000 population, respectively). This is largely driven by a 18% decrease in the fatal burden rate, while the rate of non-fatal burden increased slightly by 1.2% (Figure 5).

Trends vary considerably by condition and sex. Notably, between 2003 and 2024:

- The rate of non-fatal burden due to asthma increased by around 11%, more so among males (15% increase).
- The rate of fatal burden due to asthma decreased by around 19%, more so among females (27% decrease).
- The rate of fatal burden due to COPD decreased by 31% among males but increased 1.5% among females.
- The rate of non-fatal burden due to COPD decreased by 7.5% for all persons, with trends similar for males and females (Figure 5).

Figure 5: Burden of disease due to respiratory conditions, 2003 to 2024



Remoteness and socioeconomic areas

The latest available data on disease burden disaggregated by socioeconomic and remoteness areas is for 2018.

In 2018, after adjusting for age differences, the rate of respiratory condition burden:

- was highest for people living in *Remote* and *Very remote* areas and lowest for people living in *Major cities* (18 and 12 DALY per 1,000 population, respectively)
- was highest for people living in areas of most disadvantage (lowest socioeconomic areas) and lowest for people living in the least disadvantaged areas (highest socioeconomic areas) (17 and 9.7 DALY per 1,000 population, respectively) (AIHW 2021).

For more information, see *Australian Burden of Disease Study 2018*: Interactive data on disease burden.

Health system expenditure for respiratory conditions

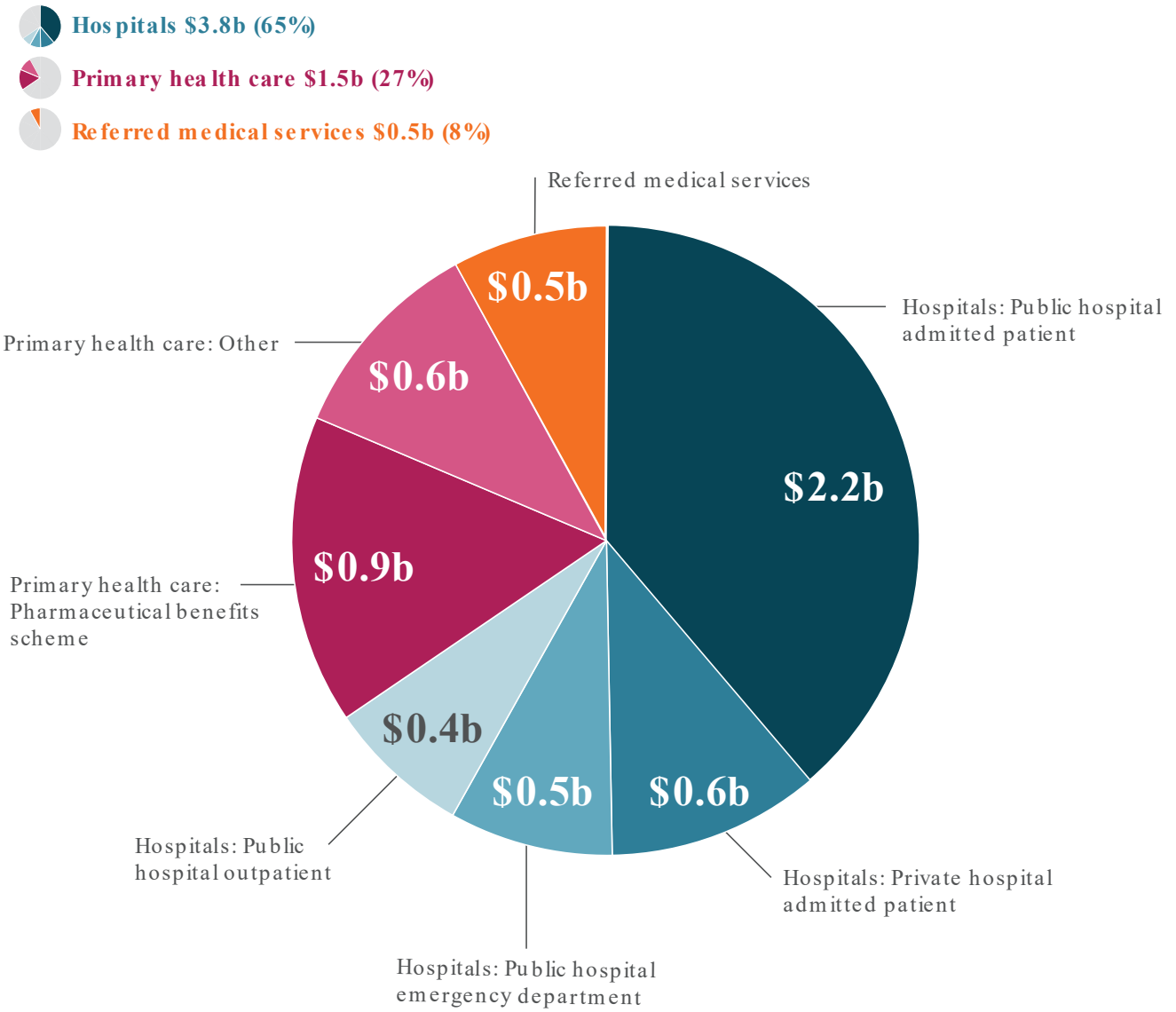
In 2023–24, an estimated **$5.8 billion** of expenditure in the Australian health system was attributed to respiratory conditions, 65% was for hospital services (predominantly public hospital admitted patient care).

In 2023–24:

- the age distribution of spending on respiratory conditions reflected the prevalence distribution, with most spending on people aged 45 and over (67%)
- the distribution of spending on respiratory conditions was split evenly between females and males ($2.9 billion each)
- by individual condition, spending was highest on COPD ($1.8 billion), followed by upper respiratory conditions (including hay fever, sinusitis and other upper respiratory tract disorders) ($1.6 billion) (AIHW 2025a).

Most health system expenditure attributable to respiratory conditions was for hospital services (65%, $3.8 billion), predominantly public hospital admitted patient care ($2.2 billion). This was followed by expenditure on primary health care (27%, $1.5 billion) and referred medical services (8.0%, $459.2 million). This pattern was generally similar to that for expenditure attributable to all disease groups.

Figure 6: Chronic respiratory conditions spending breakdown, 2023–24



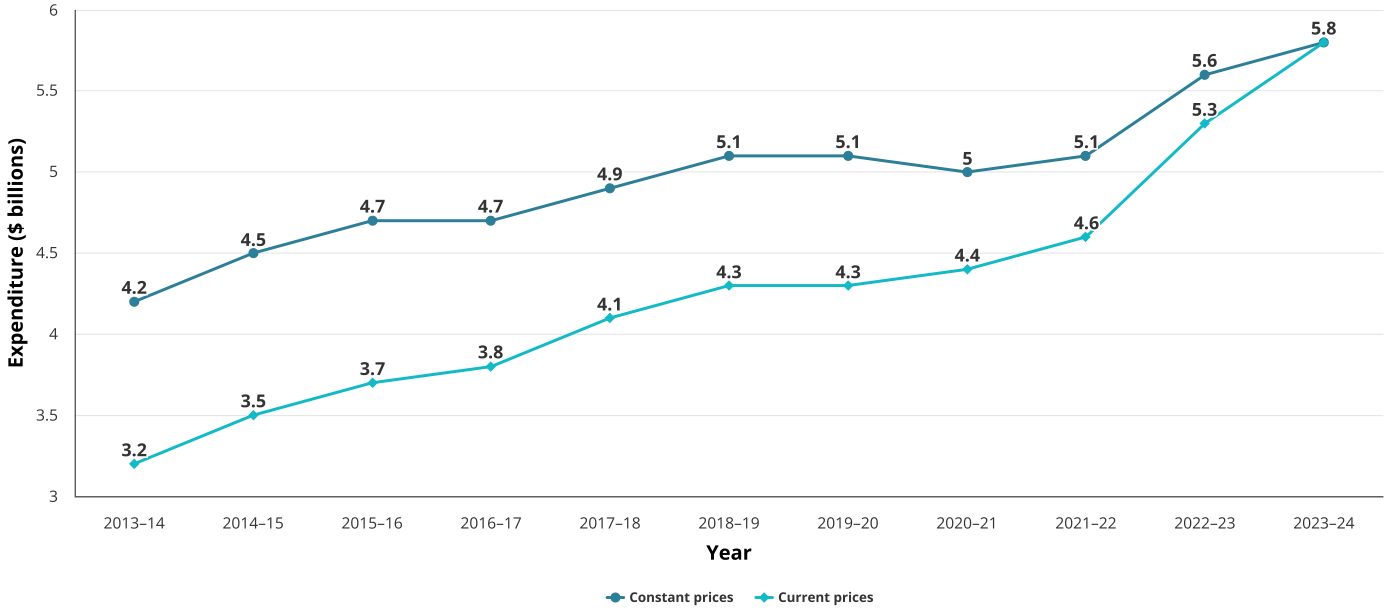
Source: AIHW Disease Expenditure database

Trends over time

Over the period 2013–14 to 2023–24:

- total spending on respiratory conditions increased from $3.2 billion to $5.8 billion (in current prices – unadjusted for inflation) (an increase of $2.6 billion)
- after adjusting for the effects of inflation, real expenditure on respiratory conditions grew 36% ($1.5 billion) (constant prices) (Figure 7)
- spending on COPD increased from $1.4 billion to $1.8 billion (constant prices) but showed a decline during the height of the COVID–19 pandemic (2020–21 and 2021–22).

Figure 7: Health system expenditure on respiratory conditions, 2013–14 to 2023–24



Source: AIHW Disease Expenditure database

For more information, see *Health system spending on disease and injury in Australia, 2023–24*.

Remoteness areas

In 2023–24, the rate of health spending attributable to respiratory conditions increased with increasing remoteness, being the highest for *Very remote* areas ($34.2 million per 100,000 population) and lowest for *Major cities* ($18.9 million per 100,000 population) (AIHW 2025a). Similar patterns were seen across total disease expenditure.

Deaths due to respiratory conditions

In 2023, respiratory conditions were recorded as an underlying and/or associated cause for **51,652 deaths** or 194 deaths per 100,000 population in Australia. This represented **28%** of all deaths in 2023.

Respiratory conditions were recorded as the underlying cause for 15,238 deaths (57 per 100,000 population), and an associated cause for 36,414 deaths (137 per 100,000 population).

- This represented 8.3% of all deaths in 2023 (underlying cause) and 20% of all deaths (associated only).
- COPD and asthma accounted for 49% and 3.2% of underlying-cause respiratory deaths, respectively. Furthermore, they contributed to 29% and 5.7% of associated-cause respiratory deaths.

In 2023, deaths due to respiratory conditions (underlying cause) were relatively more concentrated among:

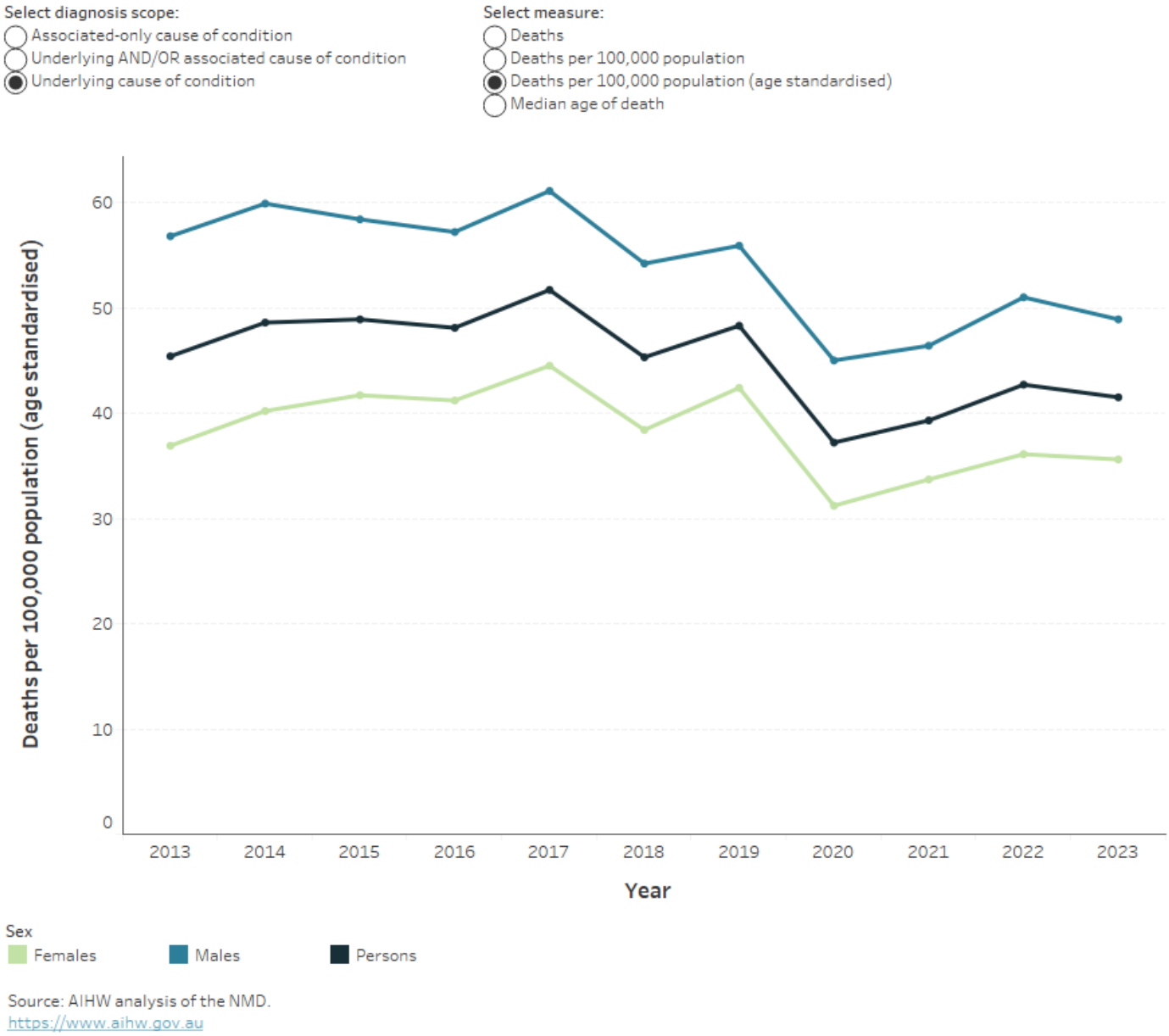
- older people (74% of respiratory deaths were among people aged 75 and over)
- males (52% of respiratory deaths were among males).

Trends over time

After adjusting for different population age structures over time, mortality rates for respiratory conditions (as the underlying cause) between 2013 and 2023:

- decreased from 45 to 42 per 100,000 population
- were higher for males compared with females (from 1.3 times in 2019 to 1.4 times in 2023) (Figure 8).

Figure 8: Deaths due to respiratory conditions mortality, 2013–2023



Remoteness and socioeconomic areas

In 2023, after adjusting for age differences, mortality rates for respiratory conditions (as the underlying cause of death) were:

- highest for people living in *Remote* and *Very remote* areas and lowest for people living in *Major cities* (63 and 38 per 100,000 population, respectively)
- highest for people living in areas of most disadvantage (lowest socioeconomic areas) and lowest for people living in the least disadvantaged areas (highest socioeconomic areas) (54 and 29 per 100,000 population, respectively).

Comorbidities of chronic respiratory conditions

People living with chronic respiratory conditions often also live with other chronic and long-term conditions, known as 'comorbidity'. According to the NHS, in 2022:

- An estimated 1.8 million people (65%) who were living with asthma also had one or more other chronic conditions. Among them, 41% were estimated to be living with mental and behavioural conditions and 25% were estimated to be living with back problems.
- An estimated 438,100 people aged 45 and over (88%) who were living with COPD also had one or more other chronic conditions. Of people aged 45 and over with COPD, 54% were estimated to be living with arthritis, 45% were estimated to be living with mental and behavioural conditions, and 45% were estimated to be living with back problems (ABS 2023b).

For more information on chronic conditions and multimorbidity, see Multimorbidity in Australia.

First Nations people

Respiratory conditions are a major cause of poor health and death for Aboriginal and Torres Strait Islander (First Nations) people.

How common are chronic respiratory conditions among First Nations people?

In 2022–23, around 311,000 First Nations people (31%) were estimated to be living with a respiratory condition, based on the latest National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) (ABS 2024).

Based on the 2022–23 NATSIHS, the prevalence of respiratory conditions:

- was higher among females compared with males (33% and 30%, respectively)
- increased with age, from 19% in children aged 0–14 to 44% in those aged 45–54 (ABS 2024).

Hospitalisations among First Nations people

In 2023–24:

- there were around 35,400 hospitalisations where a respiratory condition was the principal diagnosis for First Nations people, a rate of 3,400 per 100,000 population
- after adjusting for age differences, the hospitalisation rate among First Nations people was 2.3 times the rate among non-Indigenous Australians.

Emergency department presentations among First Nations people

In 2024–25:

- there were around 71,700 ED presentations where respiratory conditions were the principal diagnosis among First Nations people, a rate of 6,800 per 100,000 population
- the age-standardised rate of all respiratory ED presentations (principal diagnosis) was higher among First Nations women than men (7,500 and 6,200 per 100,000 population, respectively)
- after adjusting for age differences, the rate among First Nations people was 3.1 times the rate among non-Indigenous Australians.

Burden of disease among First Nations people

In 2018, the respiratory condition group accounted for 7% of total disease burden (DALY), 9% of non-fatal burden (YLD) and 6% of fatal burden (YLL) for First Nations people.

Indigenous males and females experienced burden of disease from respiratory diseases at 2.6 and 2.7 times the rates for non-Indigenous males and females, respectively (AIHW 2022).

Deaths among First Nations people

In 2023, where respiratory conditions were recorded as the underlying cause of death:

- there were 531 deaths among First Nations people, a rate of 53 per 100,000 population
- after adjusting for age differences, the rate among First Nations people was 2.2 times the rate among non-Indigenous Australians.

In 2023, where respiratory conditions were either the underlying or associated cause of death:

- there were 1,610 deaths among First Nations people, a rate of 160 per 100,000 population
- after adjusting for age differences, the rate among First Nations people was 2.0 times the rate among non-Indigenous Australians.

Further information

Further information on respiratory conditions among First Nations people is routinely reported under the Aboriginal and Torres Strait Islander Health Performance Framework Measure 1.04 Respiratory disease (AIHW 2025c).

Data gaps and opportunities

Comprehensive, accurate and timely data are necessary for effective population health monitoring of chronic respiratory conditions. Although national health information collections continue to develop and improve, some gaps remain. With a rapidly changing health data landscape, opportunities exist to expand and improve data and analysis to respond to evolving information needs and support evidence-based decision-making (AIHW 2024b).

Gaps and limitations

Current gaps on the health of people living with chronic respiratory conditions include:

- national, comparable and reportable data on primary health care activity and outcomes
- information on some population groups, including First Nations people, people with disability, culturally and linguistically diverse populations, refugees and LGBTQI+ populations
- comprehensive and routine data for finer geographical areas for service planning and delivery.

Data development and improvement

Opportunities to enhance ongoing monitoring and reporting on chronic respiratory conditions include:

- A review of the current national asthma indicators, looking at the potential to incorporate new data sources and assessing the impact of recent changes to the Australian asthma guidelines.
- Analysis to explore the environmental impact of inhalers used in the treatment of chronic respiratory conditions.
- Development of the National Primary Health Care Data Collection (NPHCDC) to provide comprehensive GP data from the primary health care setting (AIHW 2025b). This has the potential to provide a fuller picture of disease management, associated comorbidities, and long-term outcomes for chronic respiratory conditions.

Data linkage opportunities

Linked data presents an opportunity for improved understanding of the experiences and treatment patterns for people with chronic respiratory conditions. Examples of linked data sources which could be explored include:

- The National Health Data Hub: The NHDH, formerly the National Integrated Health Services Information (NIHSI) analytical asset, is a major national linked health data asset which brings together information on health services, aged care services, disability services, immunisations and demography.
- Person Level Integrated Data Asset: PLIDA, formerly the Multi-Agency Data Integration Project (MADIP), is a secure data asset combining information on health, education, government payments, income and taxation, employment, and population demographics (including the Census) over time.

Where do I go for more information?

For more information on chronic respiratory conditions, see:

- Explore chronic respiratory conditions: Asthma, COPD, Bronchiectasis, Allergic rhinitis
- Australian Bureau of Statistics (ABS) National Health Survey
- ABS Health conditions prevalence
- Australian Centre for Monitoring Population Health

References

ABS (Australian Bureau of Statistics) (2023a) *National Health Survey*, ABS website, accessed 21 November 2025.

ABS (2023b) Microdata: National Health Survey 2022, AIHW analysis of TableBuilder, accessed 9 December 2025.

ABS (2024) *National Aboriginal and Torres Strait Islander Health Survey*, ABS, Australian Government, accessed 22 September 2025.

AIHW (Australian Institute of Health and Welfare) (2021) *Australian Burden of Disease Study 2018: Interactive data on disease burden*, AIHW, Australian Government, accessed 22 May 2023.

AIHW (2022) *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018*, AIHW, Australian Government, accessed 15 December 2025.

AIHW (2024a) *Australian Burden of Disease Study 2024,* AIHW, Australian Government, accessed 20 November 2025.

AIHW (2024b) *Australia's health data landscape,* AIHW, Australian Government, accessed 27 January 2026.

AIHW (2025a) *Health system spending on disease and injury in Australia 2023–24*, AIHW, Australian Government, accessed 15 December 2025.

AIHW (2025b) *Primary health care*, AIHW, Australian Government, accessed 10 December 2025.

AIHW (2025c) Aboriginal and Torres Strait Islander Health Performance Framework, Indicator 1.04 respiratory disease (Data table D1.04.1)/ Data - AIHW Indigenous HPF, accessed 15 December 2025.

Department of Health, Disability and Ageing (2019) National Strategic Action Plan for Lung Conditions, Department of Health, Disability and Ageing, accessed 10 December 2025.

Department of Health, Disability and Ageing (2025) *Medical Research Future Fund (MRFF) grant recipients*, Department of Health, Disability and Ageing, accessed 10 December 2025.

NHMRC (National Health and Medical Research Council) (2025) *Research funding statistics and data*, NHMRC, accessed 10 December 2025.

Explore chronic respiratory conditions

Chronic respiratory conditions encompass a range of conditions affecting the airways and lungs. These articles present the latest data on the prevalence, management and impact of selected chronic respiratory conditions.

Explore related articles

Asthma

- Asthma
- First Nations people with asthma 2023
- National asthma indicators

Chronic obstructive pulmonary disease

- Chronic obstructive pulmonary disease

Bronchiectasis

- Bronchiectasis

Allergic rhinitis

- Allergic rhinitis (hay fever)

Australian Government
Australian Institute of Health and Welfare

Chronic respiratory feature analysis

Seasonal variation in chronic respiratory conditions

Last updated June 2024

Many chronic respiratory conditions are affected by environmental triggers, such as air quality and weather conditions. Acute respiratory illnesses may also worsen symptoms and necessitate changes to treatment.

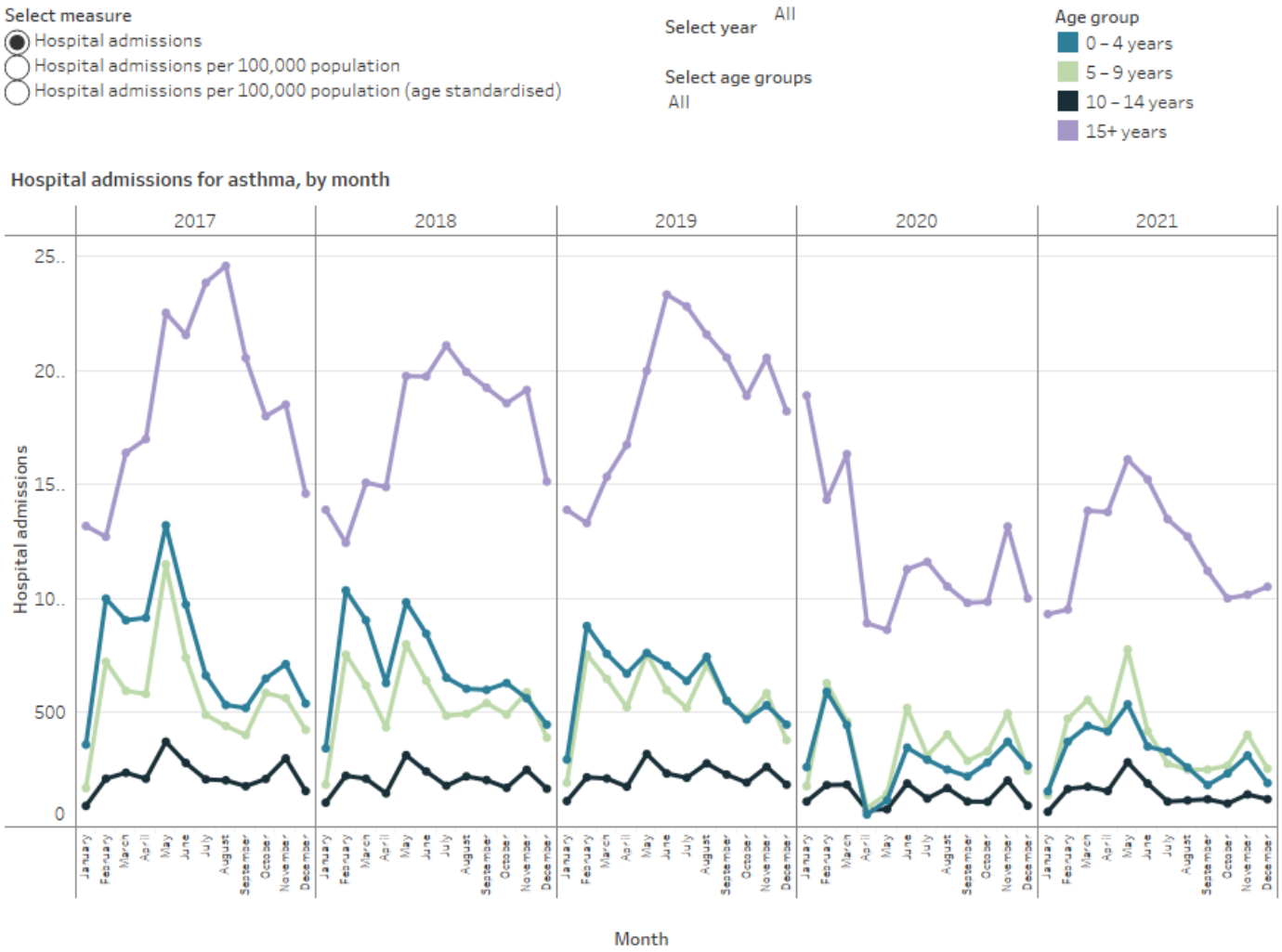
Seasonal variation in asthma hospitalisations

Among children, the peaks for asthma hospitalisations generally occur in late summer (February) and autumn (May) (Figure 1). The peak in February is likely related to respiratory infections associated with returns to school and childcare after the summer break. Lower use of preventer medication during holidays may also contribute.

2020 was an exception to this general trend, and there was a large decrease in hospitalisations in April and May for all age groups (Figure 1). This was likely due to lockdown mandates related to COVID 19. For more information on the impact of COVID 19, see Chronic respiratory conditions COVID-19 impact.

Asthma hospitalisations can also be impacted by one-off natural events which occur on a seasonal basis, such as thunderstorms and bushfires. For more information see The natural environment and chronic respiratory conditions.

Figure 1: Monthly variation in hospitalisations due to asthma, by age group, 2017 to 2021



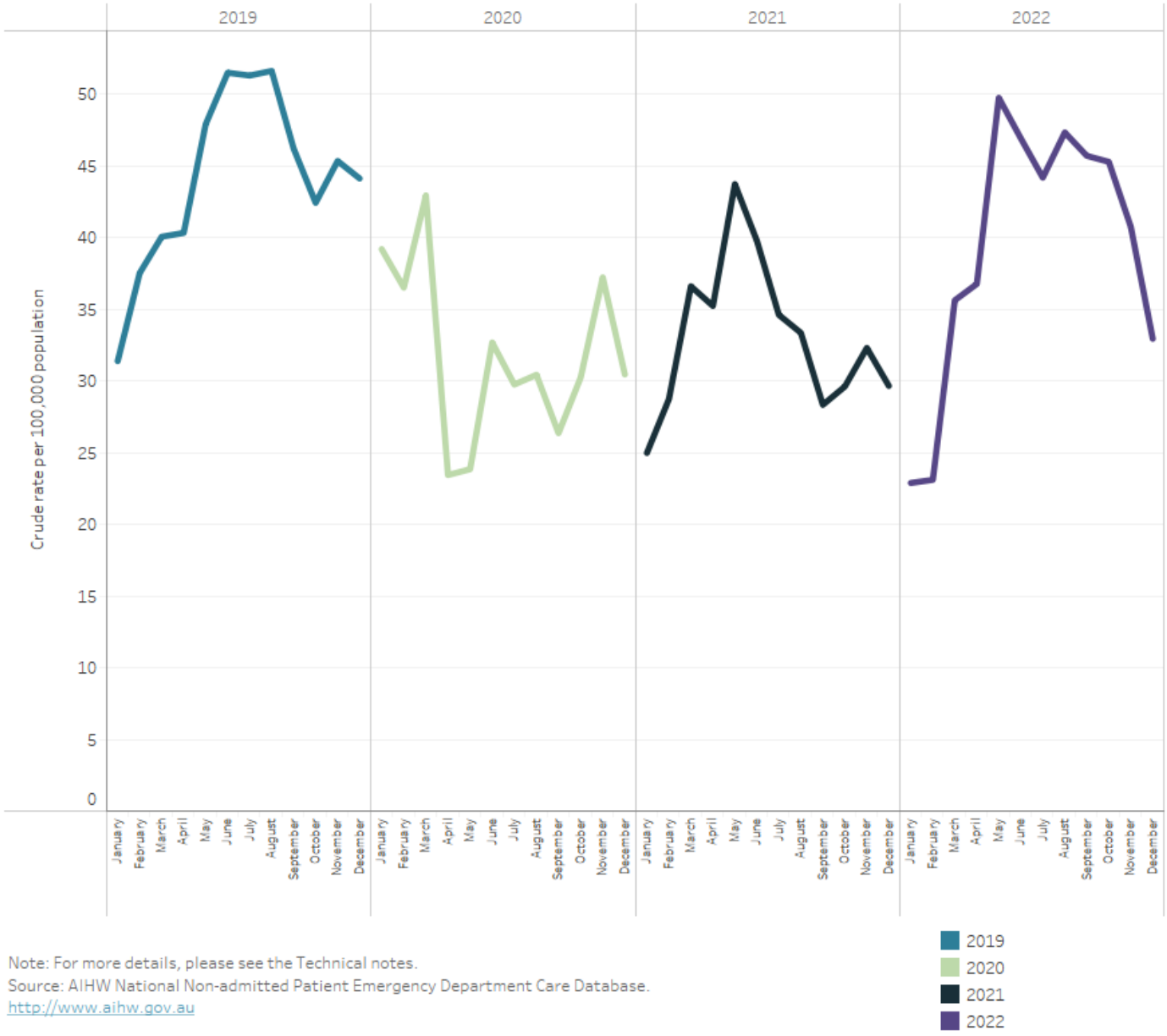
Notes
1. For more details, please see the Technical notes.
2. Rates were calculated using the June estimated resident populations.
3. Age-standardised rates were standardised to the June 2001 estimated resident population, using 5-year age groups up to 85+ years.
Source: AIHW analysis of the NHMD.
https://www.aihw.gov.au/

Seasonal variation in asthma ED presentations

Like asthma hospitalisations, asthma ED presentations can also be impacted by seasonal variation. However, differences observed between 2019 and 2020 are more likely to be due to the 2019–20 bushfire season and the COVID 19 pandemic.

In 2020, ED presentation rates decreased significantly during the nationwide lockdown from March and increased again from May. Rates for most of 2020 were lower than observed in 2019, likely due to the impact of health protection measures implemented for the pandemic (Figure 2).

Figure 2: Emergency department presentations due to asthma, by age and sex, remoteness area and socioeconomic area, 2021–22, over time (2018–19 to 2021–22) and by month (2019 to 2022)



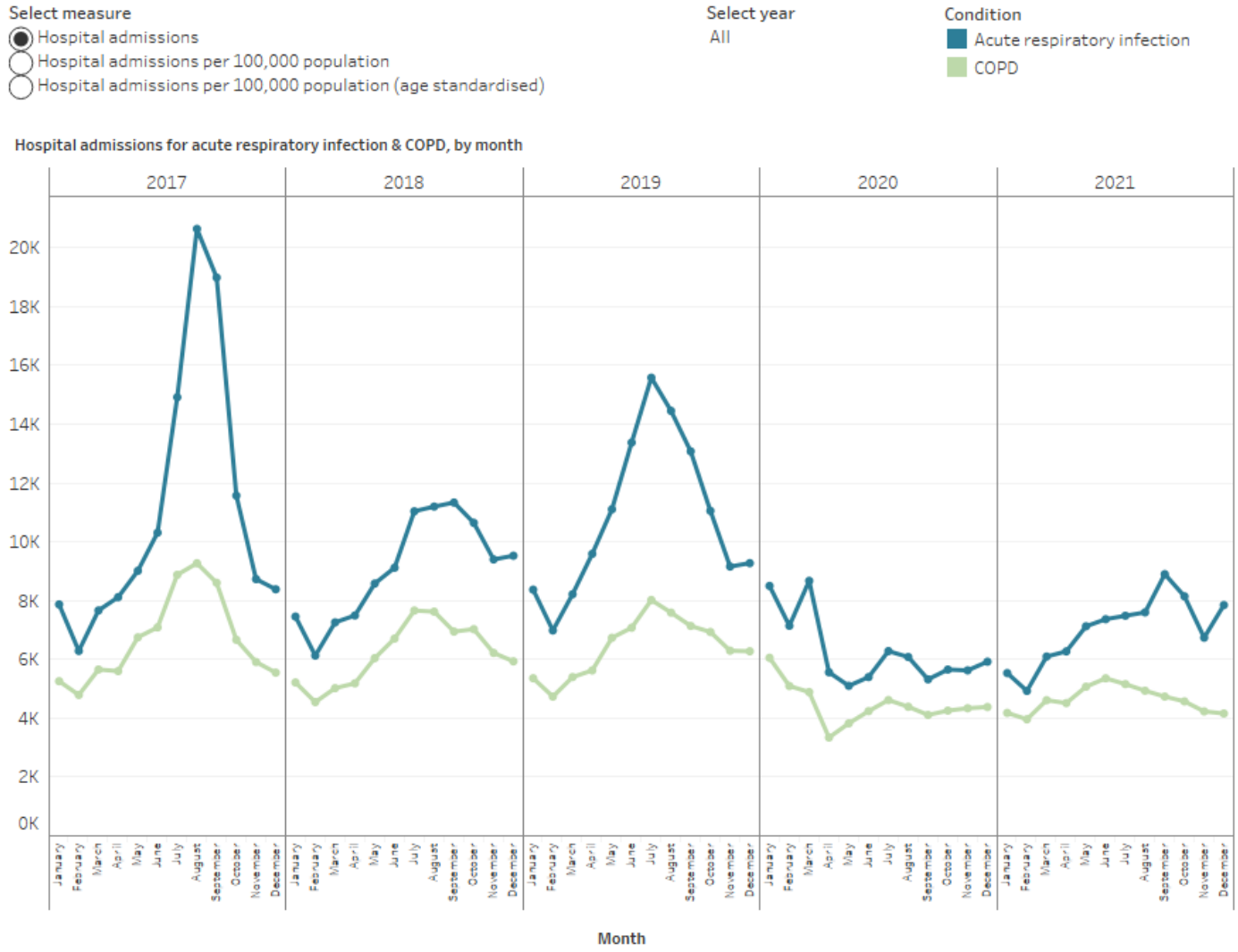
Note: For more details, please see the Technical notes.
Source: AIHW National Non-admitted Patient Emergency Department Care Database.
http://www.aihw.gov.au

Seasonal variation in COPD hospitalisations

Admissions to hospital for COPD are typically highest in winter and early spring, consistent with trends for acute respiratory infections, such as rhinovirus (common cold), influenza, pneumonia and acute bronchitis (Figure 3).

2020 was an exception to this general trend, likely due to lockdown mandates and restrictions related to COVID-19 pandemic. The lower hospitalisation rates persisted into 2021, but some typical seasonal variation over the course of the year was observed.

Figure 3: Hospitalisations due to acute respiratory infection and chronic obstructive pulmonary disease, by month, 2017–2021



Notes
1. For more details, please see the Technical notes.
2. Rates were calculated using the June estimated resident populations.
3. Age-standardised rates were standardised to the June 2001 estimated resident population, using 5-year age groups up to 85+ years.
Source: AIHW analysis of the NHMD.
https://www.aihw.gov.au/

Australian Government
Australian Institute of Health and Welfare

Asthma hospitalisations by Primary Health Care Network

Last updated June 2024

The rate of asthma hospitalisations varies across Australia. This analysis presents asthma hospitalisations by Primary Health Network areas – organisations that connect health services across a specific geographic area, with the 31 boundaries defined by the Australian Government Department of Health.

In 2020–21, the 3 PHN areas with the highest rates of hospitalisations were: Western Queensland (Qld), Northern Territory (NT), and Darling Downs and West Moreton (Qld) (245, 200 and 170 per 100,000 population, respectively), after adjusting for age.

The 3 PHN areas with the lowest hospitalisation rates were: Perth North (WA), Perth South (WA), and South Eastern NSW (NSW) (54, 54, and 59 per 100,000 population, respectively).

Hospitalisations for asthma per 100,000 population by Primary Health Network areas, age standardised rate, 2020–21

Data tables: Asthma hospitalisations by Primary Health Care Network

Data

XLSX 138kB

COVID-19 impact on chronic respiratory conditions

Last updated June 2024

The COVID-19 pandemic had substantial impacts on hospital activity generally. The range of social, economic, business and travel restrictions, including restrictions on, or suspension of, some hospital services, and associated measures in other health-care services to support physical distancing in Australia, resulted in an overall decrease in hospital activity between 2019–20 and 2020–21. As a result, the hospitalisation rates for asthma and COPD in these years were the lowest recorded in the last 10 years (AIHW 2022).

For more information on how the pandemic has affected the population's health in the context of longer-term trends, see 'Changes in the health of Australians during the COVID-19 period' in *Australia's health 2022: data insights*.

Emergency department presentations for asthma and COPD were also affected by the pandemic, decreasing from March (when the national lockdown started) to May 2020 (from 26 to 11 and 17 to 13 presentations per 100,000 population, respectively).

In June 2020, emergency department presentations increased again as restrictions began to ease across the country (to 19 presentations per 100,000 population for asthma and to 14 presentations per 100,000 population for COPD) (Figure 1).

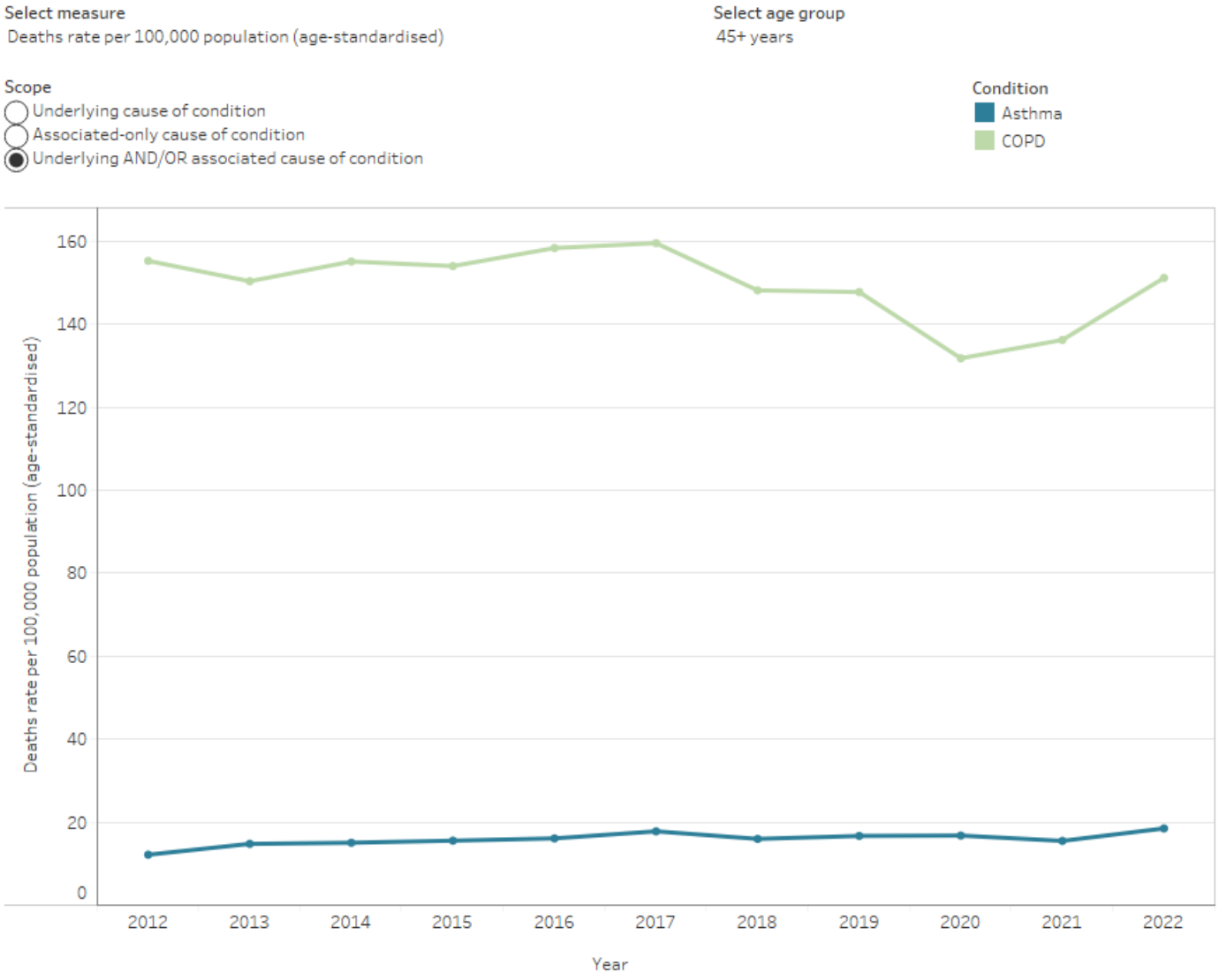
Figure 1: Monthly emergency department presentation rates for asthma and chronic obstructive pulmonary disease by age, 2019 to 2022

Notes
1. For more details, please see the Technical notes and Data tables.
2. Rates have been age-standardised to the 2001 Australian Standard Population as at 30 June 2001. For asthma, the age groups are 5-year age groups up to 85+ years. For COPD, the age groups are: 5-year age groups from 45 years up to 85+ years.
Source: AIHW National Non-admitted Patient Emergency Department Care database.
https://www.aihw.gov.au

During the COVID 19 pandemic (as at 31 October 2022), chronic respiratory conditions were certified as a pre-existing condition in 18% of the deaths with a chronic condition mentioned, the third highest of all chronic conditions (ABS 2022).

Age-standardised mortality rates due to COPD (as the underlying cause of death) decreased from 23 per 100,000 population in 2019 to 19 per 100,000 in 2020. By 2022 rates had increased to 22 per 100,000 population. Mortality rates due to asthma changed little over the same time period (Figure 2).

Figure 2: Age-standardised deaths rate due to asthma and chronic obstructive pulmonary disease, 2012 to 2022



Note: For more details, please see the Technical notes and Data tables.
Source: AIHW National Mortality Database.
https://www.aihw.gov.au/

While the long-term impact of COVID-19 on the respiratory system is still being assessed, evidence shows that COVID-19 does not directly impact the risk of increasing asthma severity and vice versa (Lee et al. 2020; Lieberman-Cribbin et al. 2020; Mather et al. 2021). However, there is increasing evidence showing that COPD patients with COVID-19 have greater risk of mortality, severity of infection and higher likelihood of requiring Intensive Care Unit (ICU) support than those without COPD (Cazzola et al. 2021; Clark et al. 2021; Wells 2021).

For more information, see 'The impact of a new disease: COVID-19 from 2020, 2021 and into 2022' in *Australia's health 2022: data insights*.

References

ABS (Australian Bureau of Statistics) (2022) *COVID-19 Mortality in Australia: Deaths registered until 31 October 2022*, ABS website, accessed 21 March 2022.

AIHW (Australian Institute of Health and Welfare) (2022) *Australia's health 2022: data insights*, *Australia's Health Series 18*. Cat. no. AUS 240, AIHW, Australian Government, accessed 14 January 2024.

Cazzola M, Ora J, Bianco A, Rogliani P and Matera MG (2021) 'Management of COPD patients during COVID: difficulties and experiences', *Expert Review of Respiratory Medicine*, 15(8):1025–1033, doi:10.1080/17476348.2021.1929176.

Clark M, Tran U and Quach J (2021) *COVID-19 Has Devastating Effects for Patients Suffering From COPD*, Pharmacy Times website, accessed 9 February 2022.

Lee SC, Son KJ, Han CH, Jung JY and Park SC (2020) 'Impact of comorbid asthma on severity of coronavirus disease (COVID-19)', *Scientific Reports*, 10(1):1–9, doi:10.1038/s41598-020-77791-8.

Lieberman-Cribbin W, Rapp J, Alpert N, Tuminello S and Taioli E (2020) 'The impact of asthma on mortality in patients with COVID-19', *Chest*, 158(6):2290–2291, doi:10.1016/j.chest.2020.05.575.

Mather JF, Mosleh W and McKay RG (2021) 'The impact of asthma on in-hospital outcomes of COVID-19 patients', *Journal of Asthma*, 29:1–7, doi:10.1080/02770903.2021.1944187.

Wells AD (2021) *COPD and COVID-19 can be a deadly combination,* Methodist Health System website, accessed 11 February 2022.

The natural environment and chronic respiratory conditions

The natural environment has the ability to affect health outcomes, particularly for people living with chronic respiratory conditions due to the impact on air quality. In Australia, bushfires and thunderstorm asthma epidemics are common events of concern.

Thunderstorm asthma

Last updated June 2024

Thunderstorm asthma can occur suddenly in spring or summer when there is a lot of pollen in the air and the weather is hot, dry, windy and stormy. People with asthma and/or hay fever need to be extra cautious to avoid flare-ups induced by thunderstorm asthma between September and January in Victoria, New South Wales and Queensland because it can be very serious (NACA 2019).

In 2016, a serious thunderstorm asthma epidemic was triggered in Melbourne when very high pollen counts coincided with adverse meteorological conditions, resulting in 3,365 people presenting at hospital emergency departments over 30 hours, and 10 deaths (Thien et al. 2018). Following this event, a Victorian thunderstorm asthma forecasting system was set up (Victoria State Government 2022).

Australian bushfires of 2019–20: Impact on COPD and asthma

Last updated June 2024

The bushfires that swept across Australia in 2019–20 resulted in 33 deaths, destruction of over 3,000 houses and millions of hectares of land (Parliament of Australia 2020). Bushfire smoke exposure was significantly associated with an increased risk of respiratory morbidity (Liu et al. 2015).

Nationally, hospitalisation rates increased for asthma and COPD coinciding with increased bushfire activity during the 2019–20 bushfire season (AIHW 2021). For asthma, the highest increase of 36% was observed in the week beginning 12 January 2020, compared with the previous 5-year average (2.4 and 1.7 per 100,000 population).

For emergency department presentations for asthma, the highest increase of 44% was observed in the same week (beginning 12 January 2020), compared with the previous bushfire season (4.7 and 3.3 per 100,000 population). See Natural environment and health.

References

AIHW (Australian Institute of Health and Welfare) (2021) *Data update: Short-term health impacts of the 2019–20 Australian bushfires*, AIHW, Australian Government, accessed 15 March 2022.

NACA (National Asthma Council Australia) (2019) *Thunderstorm asthma*, National Asthma Council Australia, Melbourne, accessed 9 February 2023.

Liu JC, Pereira G, Uhl SA, Bravo MA and Bell ML (2015) '*A systematic review of the physical health impacts from non-occupational exposure to wildfire smoke*', *Environmental Research*, 136:120–132, doi:10.1016/j.envres.2014.10.015.

Parliament of Australia (2020) *2019–20 Australian bushfires–frequently asked questions: a quick guide,* Parliament of Australia, Australian Government, accessed 9 March 2023.

Thien F, Beggs PJ, Csutoros D, Darvall J, Hew M, Davies JM, Bardin PG, Bannister T, Barnes S, Bellomo R, Byrne T, Casamento A, Conron M, Cross A, Crosswell A, Douglass JA, Durie M, Dyett J, Ebert E, Erbas B and French C (2018) '*The Melbourne epidemic thunderstorm asthma event 2016: an investigation of environmental triggers, effect on health services, and patient risk factors*', *Lancet Planet Health*, 2(6):e255–e263, doi:10.1016/S2542-5196(18)30120-7.

Victoria State Government (2022) *Epidemic thunderstorm asthma forecast*, Victoria State Government, accessed 9 March 2023.

Technical notes

In this section

National populations

The population data used are estimated resident populations (ERPs) derived from the ABS Census of Population and Housing

For more information, see National, state and territory population (ABS 2025a).

International Classifications of Disease and Related Health Problems

For causes of death

Australia uses the International Statistical Classification of Diseases and Related Health Problems (ICD) to code causes of death (WHO 2019). In this report, deaths were coded using the 10th Revision (ICD-10) (Table 1).

Table 1: International Classification of Disease (ICD) codes

Respiratory condition	ICD–10 edition codes
Asthma	J45–J46
COPD	J40–J44
Bronchiectasis	J47
All respiratory conditions	*J00–J99*

Source: WHO 2019.

For hospital diagnosis and related data

For hospital diagnoses and procedures and emergency department (ED) presentations, a classification modified for Australia is used. Hospital data were coded using the ICD-10-AM classification (International Statistical Classification of Diseases and Related Health Conditions, 10th Revision, Australian Modification) (Table 2).

Table 2: ICD-10-AM codes

Respiratory condition	ICD-10-AM 7^{th} to 11^{th} edition codes
Asthma	J45–J46
COPD	J40–J44
Bronchiectasis	J47
All respiratory conditions	*J00–J99*

Methods

Crude rates

The denominator for rate calculations was the estimated resident population (ERP) values as of 31 December for the given year (for example, crude rates for 2023–24 used the December 2023 population), unless otherwise noted.

Age-standardised rates

Age-standardisation is a method of removing the influence of age when comparing populations with different age structures – either different populations at one time or the same population at different times.

Rates are directly age-standardised in this report where possible, to enhance comparability across groups where the age structure of the population may affect interpretation.

The Australian ERP as at 30 June 2001 has been used as the standard population.

Age-standardised rates are not shown where the numerator is less than 20.

Estimated resident population values as of 31 December for the given year have been used as the denominator.

Rates that have been age-standardised are identified as such throughout the report.

Remoteness

Comparisons of regions in this report use the ABS Australian Statistical Geography Standard (ASGS) 2021 Remoteness Structure. In some instances, data for remoteness areas have been combined because of small sample sizes. Further information is available on the ABS website.

The population denominator for rates of hospitalisation by remoteness area is the mid-point average of the 30 June ERP values for the two relevant calendar years.

The 6 remoteness areas are *Major cities*, *Inner regional, Outer regional, Remote, Very remote* and *Migratory*. These areas are defined using the Accessibility/Remoteness Index for Australia (ARIA), which is a measure of the remoteness of a location from the services that large towns or cities provide.

In some instances, data for remoteness areas have been combined because of small sample sizes.

Socioeconomic areas

Socioeconomic classifications in this report are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD). Geographic areas are assigned a score based on social and economic characteristics of that area, such as income, educational attainment, public sector housing, unemployment and jobs in low-skill occupations. The IRSD relates to the average disadvantage of all people living in a geographical area. It cannot be presumed to apply to all individuals living in the area.

For the analyses in this report, the population is divided into 5 socioeconomic groups, with roughly equal populations (each around 20% of the total), based on the level of disadvantage of the statistical local area of their usual residence. The first group includes the 20% of areas with the highest levels of relative disadvantage (referred to as Group 1, most disadvantaged), while the last group includes the 20% of areas with the lowest levels of relative disadvantage (referred to as Group 5, least disadvantaged).

The IRSD values used in this report are based on the 2021 Census.

For more information on socioeconomic areas, see the Using and interpreting SEIFA (ABS 2023a).

Deriving Remoteness and Socioeconomic area statistics for 2021

The National Mortality Database includes information on people's area of usual residence prior to death. From 2022, this was at Statistical Areas Level 2 (SA2) based on the 2021 ASGS.

This location information from the National Mortality Database, along with IRSD values based on the ABS 2021 Census of Population and Housing, and estimated resident populations, have been used to derive statistics for 2021 ASGS Remoteness areas and 2021 IRSD SEIFA population based quintiles.

For more information on SA2, see the Australian Statistical Geography Standard (ABS 2023b).

Data sources

Australian Burden of Disease Database

The Australian Burden of Disease Database contains aggregate burden of disease metrics from the Australian Burden of Disease Study (ABDS) undertaken by the AIHW. This includes measures of fatal burden (years of life lost, YLL), non-fatal burden (years lived with disability, YLD) and total burden (disability-adjusted life years, DALY).

The 2024 study builds on the AIHW's previous burden of disease studies and disease monitoring work. It provides Australian-specific estimates for over 200 diseases and injuries, grouped into 17 disease groups, for 2003, 2011, 2015, 2018 and 2024.

For more information, see Australian Burden of Disease Study 2024.

Disease Expenditure Database

The AIHW Disease Expenditure Database provides a broad picture of the use of health system resources classified by disease groups and conditions.

It contains estimates of expenditure by the Australian Burden of Disease Study diseases and injuries, age group, and sex for admitted patient, emergency department and outpatient hospital services, out-of-hospital medical services, and prescription pharmaceuticals.

It does not allocate all expenditure on health goods and services by disease – for example, neither administration expenditure nor capital expenditure can be meaningfully attributed to any particular condition due to their nature.

For more information, see Topic: Health & Welfare expenditure.

Medicare Benefits Schedule

Statistics were extracted by the AIHW from the Medicare Benefits Schedule (MBS) claim records data in the Australian Government Department of Health Enterprise Data Warehouse or from online MBS published reports.

The MBS provides a subsidy for services listed in the MBS, for all Australian residents and certain categories of visitors to Australia. The major elements of Medicare are contained in the *Health Insurance Act 1973*. See details of the services covered by the MBS.

MBS items for pathology tests are subject to episode coning. Episode coning is an MBS funding arrangement that applies to general practitioners ordering more than three items in an episode for a non-hospitalised patient on the same day. Under the coning rule, Medicare benefits are only payable for the three most expensive items. The remaining items are coned out. As a result of the application of this rule, MBS data for some items will not reflect the number of tests performed for non-hospitalised patients.

Pathology services requested for hospitalised patients, or ordered by specialists, are not subject to these coning arrangements. Episode coning was introduced to prevent over servicing by doctors.

For more information, see Medicare Benefits Schedule (MBS) data collection.

National Aboriginal and Torres Strait Islander Health Survey

The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) is conducted by the ABS to obtain national information on the health of First Nations people, their use of health services and health-related aspects of their lifestyle. The ABS previously conducted the NATSIHS in 2018–19, 2012–13 and 2004–05. The most recent NATSIHS was conducted in 2022–23 (ABS 2024).

The NATSIHS collects information from First Nations people of all ages in non-remote and remote areas of Australia, including discrete First Nations communities.

For more information, see the National Aboriginal and Torres Strait Islander Health Survey

National Health Survey

The National Health Survey (NHS) is conducted by the ABS to obtain national information on the health status of Australians, their use of health services and facilities, prevalence of long-term health conditions and health risk factors. The most recent NHS was conducted in 2022.

The NHS collects self-reported data on whether a respondent had one or more long-term health conditions; that is, conditions that lasted, or were expected to last, 6 months or more.

The definition of chronic respiratory conditions from the NHS:

- The number of individuals who self-reported living with a chronic respiratory condition (current and long-term) (a person can report multiple conditions)
- 'Other' includes 'Other diseases of the respiratory system', 'Symptoms and signs involving the respiratory system'.

When interpreting data from the NHS, some limitations need to be considered:

- Data that are self-reported and as such rely on respondents knowing and providing accurate information.
- The survey does not include information from people living in nursing homes or otherwise institutionalised.
- Residents of *Very remote* areas and discrete First Nations communities were excluded from the survey. This is unlikely to affect national estimates, but will impact prevalence estimates by remoteness.

For more information, see the National Health Survey (ABS 2023c).

National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian hospitals.

Reporting to the NHMD occurs at the end of a person's admitted episode of care (separation or hospitalisation) and is based on the clinical documentation for that hospitalisation.

The NHMD is based on the Admitted Patient Care National Minimum Data Set (APC NMDS). It records information on admitted patient care (hospitalisations) in essentially all hospitals in Australia, and includes demographic, administrative and length-of-stay data, as well as data on the diagnoses of the patients, the procedures they underwent in hospital and external causes of injury and poisoning.

The hospital separations data do not include episodes of non-admitted patient care given in outpatient clinics or emergency departments. Patients in these settings may be admitted subsequently, with the care provided to them as admitted patients being included in the NHMD.

The following care types were excluded when undertaking the analysis: 7.3 (newborn – unqualified days only), 9 (organ procurement – posthumous) and 10 (hospital boarder).

Further information about the NHMD, see the National Hospitals Data Collection.

AIHW National Mortality Database

The AIHW National Mortality Database (NMD) comprises information about causes of death and other characteristics of the person, such as sex, age at death, area of usual residence and Indigenous status. The cause of death data are provided to the AIHW by the Registries of Births, Deaths and Marriages and the National Coronial Information System (managed by the Victorian Department of Justice) and include cause of death coded by the ABS. The data are maintained by the AIHW in the NMD.

In this report, deaths registered in 2021 and earlier are based on the final version of cause of death data; deaths registered in 2022 are based on the revised version; and deaths registered in 2023 are based on the preliminary version. Revised and preliminary versions are subject to further revision by the ABS.

To align with current practices and reporting by the ABS, deaths are now reported by the year in which the death was registered at the Registry of Births, Deaths, and Marriages (RBDM). Previously, the ABS reported by the reference year (the year that the ABS received the record). This has resulted in revisions to historical data from 2007 onwards.

Reporting mortality data by Indigenous status

Data from the AIHW National Mortality Database are used report the total number of deaths in Australia (nationally) among First Nations people and non-Indigenous Australians, which includes Australian residents of all states and territories. However, when reporting death rates, data have been limited to 6 jurisdictions (New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory), in which the quality of Indigenous status identification in the 2023 deaths data is considered adequate. National death rates are not published due to concerns around the quality of Indigenous status identification in Tasmania and the Australian Capital Territory. Data on the total number of deaths by Indigenous status should also be interpreted with caution due to these data quality concerns.

Data quality statements

The data quality statements underpinning the AIHW National Mortality Database can be found in the following Australian Bureau of Statistics (ABS) publications:

- ABS quality declaration summary for Deaths, Australia methodology (ABS 2025b).

- ABS quality declaration summary for Causes of death, Australia methodology (ABS 2025c).

For more information, see the National Mortality Database (NMD).

National Non-admitted Patient Emergency Department Care Database

The AIHW National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) is a compilation of episode-level records (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals. The database only captures information for physical presentations to emergency departments and does not include advice provided via telehealth or videoconferencing.

Patients being treated in emergency departments may be subsequently admitted, including admission in the emergency department, another hospital ward or to hospital-in-the-home. For this reason, there is an overlap in the scope of the NNAPEDCD NMDS and the Admitted Patient Care National Minimum Data Set (APC NMDS).

For more information, see the National Hospitals data collection.

Pharmaceutical Benefits Scheme

Statistics were extracted by the AIHW from the Pharmaceutical Benefits Scheme (PBS) records data in the Australian Government Department of Health, Disability and Ageing Enterprise Data Warehouse or from published reports.

The Australian Government subsidises the cost of a wide range of medicines through the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). Claims for reimbursement for the supply of PBS- or RPBS-subsidised medicines are submitted by pharmacies through Services Australia for processing and are provided to the Australian Government Department of Health, Disability and Ageing.

Subsidies for prescription medicines are available to all Australian residents who hold a current Medicare card, and overseas visitors from countries with which Australia has a Reciprocal Health Care Agreement. In general, patients pay a contribution to the cost of the medicine (co-payment), and the Australian Government covers the remaining cost. This remaining cost is referred to as the benefit paid.

PBS data are from records of prescriptions dispensed under the PBS and RPBS, where either:

- the Australian Government paid a subsidy
- the prescription was dispensed at a price less than the relevant patient co-payment (under co-payment prescriptions) and did not attract a subsidy.

PBS data cover all PBS prescriptions dispensed by approved suppliers, including community pharmacies, public and private hospital pharmacies and dispensing doctors.

For more information, see Pharmaceutical Benefits Scheme (PBS) data collection.

References

ABS (Australian Bureau of Statistics) (2025a) National, state and territory population, ABS website, accessed 16 December 2025.

ABS (2025b) Deaths, Australia methodology, ABS website, accessed 17 December 2025.

ABS (2025c) Causes of Death, Australia methodology, ABS website, accessed 17 December 2025.

ABS (2024) National Aboriginal and Torres Strait Islander Health Survey, ABS website, accessed 17 November 2025.

ABS (2023a) Using and interpreting SEIFA, Latest release, Socio-Economic Indexes for Areas (SEIFA): Technical Paper, ABS website, accessed 17 December 2025.

ABS (2023b) Australian Statistical Geography Standard (ASGS), ABS website, accessed 17 December 2025.

ABS (2023c) National Health Survey 2022, ABS website, accessed 7 October 2025

WHO (World Health Organization) (2019) International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), Geneva: WHO.

Notes

Amendments

5 May 2025

The following changes were made to the *Chronic respiratory conditions* web report:

- On the Summary page:
  - In the section *Deaths due to respiratory conditions*, corrections were made to mortality rates by remoteness area.
  - In the section *Deaths among First Nations people*, minor changes made to rounding of mortality rates and clarity of text.
- In the Technical notes:
  - In the section, *Methods*, reference to 'females' removed from description of population denominator for rates of hospitalisations by remoteness area as this method applies to males, females and persons.
  - In the section, *Data sources*, text was added to the AIHW National Mortality Database to describe reporting of mortality data by Indigenous status.
- On the Data page, in *Data table: Chronic respiratory conditions mortality*, *Table Resp_Mort.2: Data by Indigenous status* have been revised. Footnotes added to clarify methods used for calculating the number and rate of deaths by Indigenous status.

In the Asthma web article:

- In the section *Emergency department presentations for asthma*:
  - Corrections made to the rate of emergency department presentations for asthma in 2024–25 by socioeconomic and remoteness areas.
  - Corrections made to the comparison of ED presentation rates for females and males.
- In the section *Deaths among First Nations people*:
  - Corrections made to the mortality rate among First Nations people and the rate comparison between First Nations people and non-Indigenous Australians.

In the COPD web article:

- In the section *Main findings*, data on hospitalisations with a principal diagnosis of COPD updated from 2021–22 to 2023–24.
- In the section *Emergency department presentations for COPD*, corrections made to emergency department rates for persons aged 45+ in 2018−19 and 2024−25.
- In the section *Deaths due to COPD*, corrections made to rounding of mortality rates due to COPD.

In the Bronchiectasis web article:

- In the section *Deaths due to bronchiectasis*, text amended to clarify where morality rates are based on the underlying and/or associated cause of death.
- In the section *Deaths among First Nations people*:
  - Corrections made to the mortality rate among First Nations people and the rate comparison between First Nations people and non-Indigenous Australians.
  - Text amended to clarify where morality rates are based on the underlying and/or associated cause of death.

Data sources

These web articles were last updated on 18 February 2026. See table below for details of updates by data source.

Updates to content by data source

Topic	Data source	Latest time period reported	Measure content last update
Burden of Disease	Australian Burden of Disease Study 2024	2024	18 February 2026
Health expenditure	Health system spending on disease and injury in Australia 2023–24	2023–24	18 February 2026
Hospitalisations	National Hospital Morbidity Database (NHMD)	2023–24	18 February 2026
Deaths	National Mortality Database (NMD)	2023	18 February 2026
Emergency Department (ED) presentations	National Non-Admitted Patient Emergency Department Care Database (NAPEDC)	2024–25	18 February 2026
Medications use	Pharmaceutical Benefits Scheme (PBS)	2022–23	27 November 2024
Medicare service use	Medicare Benefits Schedule (MBS)	2021–22	30 June 2023
Prevalence (survey, self-report)	National Health Survey	2022	17 June 2024

Data

ABS data tables: National Health Survey 2022

Resource

Australian Bureau of Statistics website

Data tables: Chronic respiratory conditions NHS and NATSIHS

Data

XLSX 44kB

Data tables: Chronic respiratory conditions admitted patient care

Data

XLSX 588kB

Data tables: Chronic respiratory conditions emergency department

Data

XLSX 124kB

Data tables: Chronic respiratory conditions expenditure

Data

XLSX 34kB

Data tables: Chronic respiratory conditions mortality

Data

XLSX 169kB

Related material

Resources

The burden of chronic respiratory conditions in Australia: a detailed analysis of the Australian Burden of Disease Study 2011

Resource

Strengthening national COPD monitoring using linked health services data

Resource

Latest related reports

- Asthma |
  Web article | 18 Feb 2026
- Chronic obstructive pulmonary disease |
  Web article | 18 Feb 2026
- National asthma indicators |
  Web article | 18 Feb 2026
- Allergic rhinitis (hay fever) |
  Web article | 18 Feb 2026
- Bronchiectasis |
  Web article | 18 Feb 2026
- First Nations people with asthma 2023 |
  Web article | 14 Dec 2023

Related topics

- Chronic disease
- Chronic respiratory conditions